Assembly Bill No. 1832

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Passed the Assembly August 31, 1996

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Chief Clerk of the Assembly

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Passed the Senate August 23, 1996

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Secretary of the Senate

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This bill was received by the Governor this ___ day

of _____, 1996, at ___ o'clock __M.

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Private Secretary of the Governor

CHAPTER ____

An act to amend Sections 3750, 3767, 5283, 7571, 7572, and 7644 of, to add Sections 3751.5, 7573, and 7577 to, and to repeal and add Sections 7574, 7575, and 7576 of, the Family Code, to amend Section 22825.14 of the Government Code, to amend Sections 1357, 1357.50, 1374.3, and 102425 of, and to add Article 4 (commencing with Section 102766) to Chapter 5 of Part 1 of Division 102 of, the Health and Safety Code, to amend Sections 10119, 10121.6, 10198.6, 10702.1, 10711, 10719.1, 10731.2, and 11516.1 of the Insurance Code, to amend Section 2803.5 of the Labor Code, and to amend Sections 11350.3, 11350.4, 11476, 11478.8, 15200.1, 15200.2, 15200.3, 15200.7, 15200.8, 15200.85, 15200.9, and 15200.95 of, to add Sections 14124.94 and 15200.91 to, and to repeal Section 14124.93 of, the Welfare and Institutions Code, relating to family law, and making an appropriation therefor.

LEGISLATIVE COUNSEL'S DIGEST

AB 1832, Speier. Family law: support: paternity.

(1) Existing law authorizes the court to require health care coverage payments in child support proceedings. Existing law requires the district attorney, the State Department of Health Services, or a party with custody of a child to enforce an outstanding support order that requires that health care coverage be provided to the child, and requires support obligors and their employers and health care insurers, as defined, to comply with these provisions, in the case of a child eligible for federal medicaid services.

This bill would require support obligors and their employers and health care insurers to comply with certain provisions relative to a support order requiring health care coverage to be provided to any child. These children would be included within the health care coverage provided by employers or other providers, as specified. The changes made by this bill to Section 11516.1

of the Insurance Code would not become operative if SB 1866, which would repeal that section, is enacted.

(2) Existing law also requires employers and labor organizations to cooperate with and provide relevant employment and income information, upon request, to a district attorney enforcing child support obligations. An employer or labor organization may be assessed a civil penalty of a maximum of $500 for failure to provide that information within 30 days of receiving a request, as specified.

This bill would increase the maximum civil penalties that may be imposed upon an employer or labor organization for failing to provide relevant employment information to the district attorney regarding the enforcement of a support obligation, as specified. The bill would also define ‘‘employer’’ for purposes of these provisions, and would require employees to provide information about earnings, as defined, to a district attorney enforcing child support obligations, on request.

(3) Existing law specifies procedures for the establishment of paternity by voluntary declaration. Under these provisions, the child of a woman and a man executing a declaration of paternity is conclusively presumed to be the man’s child. This presumption may be rebutted by way of blood or genetic tests within 3 years of the date of execution of the declaration, as provided. Existing law specifies the contents of the declaration, and requires each district attorney to pay $10 to a hospital, clinic, or other place of live birth for each declaration filed.

This bill would revise and recast these provisions and would, among other things, delete the requirement that clinics and birthing centers provide a voluntary declaration of paternity upon the event of a live birth; authorize prenatal clinics to file voluntary declarations of paternity; make special provision for minors who sign a declaration; provide that a completed voluntary declaration of paternity that has been filed with the State Office of Vital Records establishes the paternity of the child and has the same force and effect as a judgment for

paternity issued by a court of competent jurisdiction; revise the contents of the declaration; provide a 60-day period in which a parent may rescind the voluntary declaration of paternity, except as provided; authorize a court to set aside a voluntary declaration of paternity under certain conditions; and make special provision for declarations signed on or before December 31, 1996. By requiring increased duties of local officials, the bill would impose a state-mandated local program.

(4) Existing law requires a certificate of live birth to contain specified information, including the full name, birthplace, and date of birth of the father.

This bill would provide that if the parents are not married to each other, the father's name shall not be listed on the birth certificate unless the father and mother sign a voluntary declaration of paternity at the hospital before the birth certificate is prepared, as specified. This bill would also establish a procedure for the establishment of a new birth certificate when a voluntary declaration of paternity is filed with the State Registrar, and would make related changes.

(5) Existing law requires the district attorney, in specified actions filed by the district attorney, to provide the mother and the alleged father the opportunity to voluntarily acknowledge paternity by signing a voluntary declaration of paternity prior to a hearing or trial where the paternity of a minor child is at issue.

This bill would authorize the district attorney, for the purpose of meeting this requirement, to afford the defendant an opportunity to enter into a stipulation for judgment of paternity.

(6) Existing law, operative July 1, 1997, appropriates federal incentive funds out of any money in the State Treasury not otherwise appropriated, from which the State Department of Social Services shall make payments to each county (a) on any support payments collected or distributed, or both, and (b) on any interstate support collections collected or distributed, or both, and provides for the payment to counties of state incentive funds.

This bill would change the operative date of these provisions to July 1, 1998.

(7) Existing law, operative July 1, 1997, appropriates out of any money in the General Fund not otherwise appropriated, amounts from which the State Department of Social Services shall make federal incentive payments to each county on nonfederally funded foster care support payments collected or distributed, and provides for the payment to counties of state incentive funds.

This bill would change the operative date of this provision to July 1, 1998.

(8) Existing law, operative July 1, 1997, annually appropriates from the General Fund to the State Department of Social Services beginning in fiscal year 1997–98, a sum equal to 50% of the state's share of increased AFDC child support collections, as specified.

This bill would change the operative date of this provision to July 1, 1998.

(9) Existing law, operative until June 30, 1997, requires the State Department of Social Services to establish a performance-based incentive system which will provide federal and state incentive funds to counties based on standards of performance in the child support program, as provided. Existing law, operative until June 30, 1997, appropriates from the State Treasury sufficient funds, including federal incentives, from which the department shall pay (a) to each county a base rate of 10% on any support collections distributed, and (b) to certain counties a performance rate, and requires the department to pay to certain counties a specified compliance incentive rate.

This bill would extend the operative date of these provisions to June 30, 1998.

(10) Existing law, operative until June 30, 1997, provides for county and state responsibility for each counties' share of administrative expenditures for administering the child support program, and revises these provisions, operative July 1, 1997.

This bill would revise these operative dates to June 30, 1998, and July 1, 1998, respectively.

(11) This bill would incorporate additional changes in Section 1357 of the Health and Safety Code, proposed by AB 8 and SB 371, to be operative only if AB 8, SB 371, or both, and this bill are chaptered, either bill or both of those bills and this bill become effective on or before January 1, 1997, and this bill is chaptered last.

(12) The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement, including the creation of a State Mandates Claims Fund to pay the costs of mandates that do not exceed $1,000,000 statewide and other procedures for claims whose statewide costs exceed $1,000,000.

This bill would provide that, if the Commission on State Mandates determines that the bill contains costs mandated by the state, reimbursement for those costs shall be made pursuant to these statutory provisions.

Appropriation: yes.

The people of the State of California do enact as follows:

SECTION 1. Section 3750 of the Family Code is amended to read:

3750. ''Health insurance coverage'' as used in this article includes all of the following:

(a) Vision care and dental care coverage whether the vision care or dental care coverage is part of existing health insurance coverage or is issued as a separate policy or plan.

(b) Provision for the delivery of health care services by a fee for service, health maintenance organization, preferred provider organization, or any other type of health care delivery system under which medical services could be provided to a dependent child of an absent parent.

SEC. 2. Section 3751.5 is added to the Family Code, to read:

3751.5. (a) Notwithstanding any other provision of law, an employer or insurer shall not deny enrollment of

a child under the health insurance coverage of a child's parent on any of the following grounds:

(1) The child was born out of wedlock.

(2) The child is not claimed as a dependent on the parent's federal income tax return.

(3) The child does not reside with the parent or in the insurer's service area.

(b) Notwithstanding any other provision of law, in any case in which a parent is required by a court or administrative order to provide health insurance coverage for a child and the parent is eligible for family health coverage through an employer doing business in the state or an insurer, the employer or insurer shall do all of the following, as applicable:

(1) Permit the parent to enroll under health insurance coverage any child who is otherwise eligible to enroll for that coverage, without regard to any enrollment period restrictions.

(2) If the parent is enrolled in health insurance coverage but fails to apply to obtain coverage of the child, enroll that child under the health coverage upon presentation of the court order or request by the district attorney, the other parent or person having custody of the child, or the Medi-Cal program.

(3) The employer or insurer shall not disenroll or eliminate coverage of a child unless either of the following applies:

(A) The employer has eliminated family health insurance coverage for all of the employer's employees.

(B) The employer or insurer is provided with satisfactory written evidence that either of the following apply:

(i) The court order or administrative order is no longer in effect or is terminated pursuant to Section 3770.

(ii) The child is or will be enrolled in comparable health insurance coverage through another insurer that will take effect not later than the effective date of the child's disenrollment.

(c) For purposes of this section, ''insurer'' includes every health care service plan, self-insured welfare

benefit plan, including those regulated pursuant to the Employee Retirement Income Security Act of 1974 (29 U.S.C. Sec. 1001, et seq.), self-funded employer plan, disability insurer, nonprofit hospital service plan, labor union trust fund, employer, and any other similar plan, insurer, or entity offering a health coverage plan.

(d) For purposes of this section, ‘‘person having custody of the child’’ is defined as a legal guardian, a caregiver who is authorized to enroll the child in school or to authorize medical care for the child pursuant to Section 6550, or a person with whom the child resides.

SEC. 3. Section 3767 of the Family Code is amended to read:

3767. The employer or other person providing health insurance shall do all of the following:

(a) Notify the applicant for the assignment order of the commencement date of the coverage of the child.

(b) Provide evidence of coverage and any information necessary for the child to obtain benefits through the coverage to both parents or the person having custody of the child and to the district attorney when requested by the district attorney.

(c) Upon request by the parents or person having custody of the child, provide all forms and other documentation necessary for the purpose of submitting claims to the insurance carrier which the employer or other person providing health insurance usually provides to insureds.

(d) Permit the parent or the person having custody of the child, or a provider with the approval of either the parent or the person having custody of the child, to submit claims for covered services on behalf of the child without the approval of the covered parent.

(e) Make payments on claims submitted in accordance with subdivision (d) directly to either parent or the person having custody, to the provider, or to the State Department of Health Services.

SEC. 3.5. Section 5283 of the Family Code is amended to read:

5283. (a) Upon receipt of a written request from a district attorney enforcing the obligation of parents to support their children pursuant to Section 11475.1 of the Welfare and Institutions Code, every employer shall cooperate with and provide relevant employment and income information, including information on earnings, as specified, in Section 5206, that the employer has in its possession, to the district attorney for the purpose of establishing, modifying, or enforcing the support obligation. No employer shall incur any liability for providing this information to the district attorney.

(b) Relevant employment and income information shall include, but not be limited to, all of the following:

(1) Whether a named person has or has not been employed by an employer.

(2) The full name of the employee or the first and middle initial and last name of the employee.

(3) The employee's last known residence address.

(4) The employee's date of birth.

(5) The employee's social security number.

(6) The dates of employment.

(7) All earnings paid to the employee and reported as W-2 compensation in the prior tax year and the employee's current basic rate of pay.

(8) Whether dependent health insurance coverage is available to the employee through employment.

(c) The district attorney shall notify the employer of the district attorney case file number in making a request pursuant to this section. The written request shall include at least three of the following elements regarding the person who is the subject of the inquiry:

(1) First and last name and middle initial, if known.

(2) Social security number.

(3) Driver's license number.

(4) Birth date.

(5) Last known address.

(6) Spouse's name.

(d) An employer who fails to provide relevant employment information to the district attorney within 30 days of receiving a request pursuant to subdivision (a)

may be assessed a civil penalty of a maximum of one thousand dollars ($1,000), plus attorneys' fees and costs. Proceedings to impose the civil penalty shall be commenced by the filing and service of an order to show cause.

SEC. 4. Section 7571 of the Family Code is amended to read:

7571. (a) On and after January 1, 1995, upon the event of a live birth, prior to an unmarried mother leaving any hospital, the person responsible for registering live births under Section 102405 of the Health and Safety Code shall provide to the natural mother and shall attempt to provide, at the place of birth, to the man identified by the natural mother as the natural father, a voluntary declaration of paternity together with the written materials described in Section 7572. The person responsible for registering the birth shall file the declaration, if completed, with the birth certificate, and, if requested, shall transmit a copy of the declaration to the district attorney of the county where the birth occurred. A copy of the declaration shall be made available to each of the attesting parents.

(b) No health care provider shall be subject to any civil, criminal, or administrative liability for any negligent act or omission relative to the accuracy of the information provided, or for filing the declaration with the appropriate state or local agencies.

(c) The district attorney shall pay the sum of ten dollars ($10) to birthing hospitals and other entities that provide prenatal services for each completed declaration of paternity that is filed with the State Office of Vital Records, provided that the district attorney and the hospital or other entity providing prenatal services has entered into a written agreement that specifies the terms and conditions for the payment as required by federal law.

(d) If the declaration is not registered by the person responsible for registering live births at the hospital, it may be completed by the attesting parents, notarized,

and mailed to the State Office of Vital Records at any time after the child's birth.

(e) Prenatal clinics may offer prospective parents the opportunity to sign a voluntary declaration of paternity. In order to be paid for their services as provided in subdivision (c), prenatal clinics must ensure that the form is witnessed and forwarded to the State Office of Vital Records.

(f) Declarations shall be made available without charge at all district attorney offices, offices of local registrars of births and deaths, courts, and county welfare departments within this state. Staff in these offices shall witness the signatures of parents wishing to sign a voluntary declaration of paternity and shall be responsible for forwarding the signed declaration to the State Office of Vital Records and Statistics.

(g) The State Department of Social Services and district attorneys shall publicize the availability of the declarations. The district attorney shall make the declaration, together with the written materials described in subdivision (a) of Section 7572, available upon request to any parent. The district attorney shall also provide qualified staff to answer parents' questions regarding the declaration and the process of establishing paternity.

(h) Copies of the declaration filed with the State Office of Vital Records and Statistics shall be made available only to the parents, the child, the district attorney, the county welfare department, the county counsel, and the State Department of Social Services.

SEC. 5. Section 7572 of the Family Code is amended to read:

7572. (a) The State Department of Social Services, in consultation with the State Department of Health Services, the California Association of Hospitals and Health Systems, and other affected health provider organizations, shall work cooperatively to develop written materials to assist providers and parents in complying with this chapter.

(b) The written materials for parents which shall be attached to the form specified in Section 7574 and provided to unmarried parents shall contain the following information:

(1) A signed voluntary declaration of paternity that is filed with the State Office of Vital Records and Statistics legally establishes paternity.

(2) The legal rights and obligations of both parents and the child that result from the establishment of paternity.

(3) An alleged father's constitutional rights to have the issue of paternity decided by a court; to notice of any hearing on the issue of paternity; to have an opportunity to present his case to the court, including his right to present and cross-examine witnesses; to have an attorney represent him; and to have an attorney appointed to represent him if he cannot afford one in a paternity action filed by the district attorney.

(4) That by signing the voluntary declaration of paternity, the father is voluntarily waiving his constitutional rights.

(c) The State Department of Social Services shall, free of charge, make available to hospitals, clinics, and other places of birth any and all informational and training materials for the program under this chapter, as well as the paternity declaration form. The State Department of Social Services shall make training available to every hospital, clinic, and other place of birth no later than October 31, 1994.

(d) The State Department of Social Services may adopt regulations, including emergency regulations, necessary to implement this chapter.

SEC. 6. Section 7573 is added to the Family Code, to read:

7573. Except as provided in Sections 7575, 7576, and 7577, a completed voluntary declaration of paternity, as described in Section 7574, that has been filed with the State Office of Vital Records shall establish the paternity of a child and shall have the same force and effect as a judgment for paternity issued by a court of competent jurisdiction. The voluntary declaration of paternity shall

be recognized as a basis for the establishment of an order for child custody, visitation, or child support.

SEC. 7. Section 7574 of the Family Code is repealed.

SEC. 8. Section 7574 is added to the Family Code, to read:

7574. (a) The voluntary declaration of paternity shall be executed on a form developed by the State Department of Social Services in consultation with the State Department of Health Services, the California Family Support Council, and child support advocacy groups.

(b) The form described in subdivision (a) shall contain, at a minimum, the following:

(1) The name and the signature of the mother.

(2) The name and the signature of the father.

(3) The name of the child.

(4) The date of birth of the child.

(5) A statement by the mother that she has read and understands the written materials described in Section 7572, that the man who has signed the voluntary declaration of paternity is the only possible father, and that she consents to the establishment of paternity by signing the voluntary declaration of paternity.

(6) A statement by the father that he has read and understands the written materials described in Section 7572, that he understands that by signing the voluntary declaration of paternity he is waiving his rights as described in the written materials, that he is the biological father of the child, and that he consents to the establishment of paternity by signing the voluntary declaration of paternity.

(7) The name and the signature of the person who witnesses the signing of the declaration by the mother and the father.

SEC. 9. Section 7575 of the Family Code is repealed.

SEC. 10. Section 7575 is added to the Family Code, to read:

7575. (a) Either parent may rescind the voluntary declaration of paternity by filing a rescission form with the State Office of Vital Records within 60 days of the date

of execution of the declaration by the attesting father or attesting mother, whichever signature is later, unless a court order for custody, visitation, or child support has been entered in an action in which the signatory seeking to rescind was a party. The State Department of Social Services shall develop a form to be used by parents to rescind the declaration of paternity and instruction on how to complete and file the rescission with the State Office of Vital Records. The form shall include a declaration under penalty of perjury completed by the person filing the rescission form that certifies that a copy of the rescission form was either hand delivered or mailed to the other person who signed the voluntary declaration of paternity. The form and instructions shall be written in simple, easy to understand language and shall be made available at the local family support office and the office of local registrar of births and deaths.

(b) (1) Notwithstanding Section 7573, if the court finds that the conclusions of all of the experts based upon the results of the blood tests performed pursuant to Chapter 2 (commencing with Section 7550) are that the man who signed the voluntary declaration is not the father of the child, the court may set aside the voluntary declaration of paternity.

(2) The notice of motion for blood tests under this section may be filed not later than two years from the date of the child's birth by either the mother or the man who signed the voluntary declaration as the child's father in an action to determine the existence or nonexistence of the father and child relationship pursuant to Section 7630 or in any action to establish an order for child custody, visitation, or child support based upon the voluntary declaration of paternity.

(3) The notice of motion for blood tests pursuant to this section shall be supported by a declaration under oath submitted by the moving party stating the factual basis for putting the issue of paternity before the court.

(c) (1) Nothing in this chapter shall be construed to prejudice or bar the rights of either parent to file an action or motion to set aside the voluntary declaration of

paternity on any of the grounds described in, and within the time limits specified in, Section 473 of the Code of Civil Procedure and Chapter 10 (commencing with Section 2120) of Part 1 of Division 6. If the action or motion to set aside the voluntary declaration of paternity is for fraud or perjury, the act must have induced the defrauded parent to sign the voluntary declaration of paternity. If the action or motion to set aside a judgment is required to be filed within a specified time period under Section 473 of the Code of Civil Procedure or Section 2122, the period within which the action or motion to set aside the voluntary declaration of paternity must be filed shall commence on the date that the court makes a finding of paternity based upon the voluntary declaration of paternity in an action for custody, visitation, or child support.

(2) The parent seeking to set aside the voluntary declaration of paternity shall have the burden of proof.

(3) Any order for custody, visitation, or child support shall remain in effect until the court determines that the voluntary declaration of paternity should be set aside, subject to the court's power to modify the orders as otherwise provided by law.

(4) Nothing in this section is intended to restrict a court from acting as a court of equity.

(5) If the voluntary declaration of paternity is set aside pursuant to paragraph (1), the court shall order that the mother, child, and alleged father submit to blood or genetic tests pursuant to Chapter 2 (commencing with Section 7550). If the court finds that the conclusions of all the experts, as disclosed by the evidence based upon the blood or genetic tests, are that the person who executed the voluntary declaration of paternity is not the father of the child, the question of paternity shall be resolved accordingly. If the person who executed the declaration as the father of the child is not excluded as a possible father, the question of paternity shall be resolved as otherwise provided by law. If the person who executed the declaration of paternity is ultimately determined to be the father of the child, any child support that accrued

under an order based upon the voluntary declaration of paternity shall remain due and owing.

(6) The Judicial Council shall develop the forms and procedures necessary to effectuate this subdivision.

SEC. 11. Section 7576 of the Family Code is repealed.

SEC. 12. Section 7576 is added to the Family Code to read:

7576. The following provisions shall apply for voluntary declarations signed on or before December 31, 1996.

(a) Except as provided in subdivision (d), the child of a woman and a man executing a declaration of paternity under this chapter is conclusively presumed to be the man's child. The presumption under this section has the same force and effect as the presumption under Section 7540.

(b) A voluntary declaration of paternity shall be recognized as the basis for the establishment of an order for child custody or support.

(c) In any action to rebut the presumption created by this section, a voluntary declaration of paternity shall be admissible as evidence to determine paternity of the child named in the voluntary declaration of paternity.

(d) The presumption established by this chapter may be rebutted by any person by requesting blood or genetic tests pursuant to Chapter 2 (commencing with Section 7550). The notice of motion for blood or genetic tests pursuant to this section shall be supported by a declaration under oath submitted by the moving party stating the factual basis for placing the issue of paternity before the court. The notice of motion for blood tests shall be made within three years from the date of execution of the declaration by the attesting father, or by the attesting mother, whichever signature is later. The two-year statute of limitations specified in subdivision (b) of Section 7541 is inapplicable for purposes of this section.

(e) A presumption under this chapter shall override all statutory presumptions of paternity except a presumption arising under Section 7540 or 7555.

SEC. 13. Section 7577 is added to the Family Code to read:

7577. (a) Notwithstanding Section 7573, a voluntary declaration of paternity that is signed by a minor parent or minor parents shall not establish paternity until 60 days after both parents have reached the age of 18 years or are emancipated, whichever first occurs.

(b) A parent who signs a voluntary declaration of paternity when he or she is a minor may rescind the voluntary declaration of paternity at any time up to 60 days after the parent reaches the age of 18 or becomes emancipated whichever first occurs.

(c) A voluntary declaration of paternity signed by a minor creates a rebuttable presumption of paternity until the date that it establishes paternity as specified in subdivision (a).

(d) A voluntary declaration of paternity signed by a minor shall be admissible as evidence in any civil action to establish paternity of the minor named in the voluntary declaration.

(e) A voluntary declaration of paternity that is signed by a minor shall not be admissible as evidence in a criminal prosecution for violation of Section 261.5 of the Penal Code.

SEC. 14. Section 7644 of the Family Code is amended to read:

7644. (a) Notwithstanding any other law, an action for child custody and support and for other relief as provided in Section 7637 may be filed based upon a voluntary declaration of paternity as provided in Chapter 3 (commencing with Section 7570) of Part 2.

(b) Except as provided in Section 7576, the voluntary declaration of paternity shall be given the same force and effect as a judgment of paternity entered by a court of competent jurisdiction. The court shall make appropriate orders as specified in Section 7637 based upon the voluntary declaration of paternity unless evidence is presented that the voluntary declaration of paternity has been rescinded by the parties or set aside as provided in Section 7575 of the Family Code.

(c) The Judicial Council shall develop the forms and procedures necessary to implement this section.

SEC. 15. Section 22825.14 of the Government Code is amended to read:

22825.14. Any person or entity subject to the requirements of this chapter shall comply with the standards set forth in Chapter 7 (commencing with Section 3750) of Part 1 of Division 9 of the Family Code and Section 14124.94 of the Welfare and Institutions Code.

SEC. 16. Section 1357 of the Health and Safety Code is amended to read:

1357. As used in this article:

(a) ''Dependent'' means the spouse or child of an eligible employee, subject to applicable terms of the health care plan contract covering the employee, and includes dependents of guaranteed association members if the association elects to include dependents under its health coverage at the same time it determines its membership composition pursuant to subdivision (o).

(b) ''Eligible employee'' means either of the following:

(1) Any permanent employee who is actively engaged on a full-time basis in the conduct of the business of the small employer with a normal workweek of at least 30 hours, at the small employer's regular places of business, who has met any statutorily authorized applicable waiting period requirements. The term includes sole proprietors or partners of a partnership, if they are actively engaged on a full-time basis in the small employer's business and included as employees under a health care plan contract of a small employer, but does not include employees who work on a part-time, temporary, or substitute basis. It includes any eligible employee as defined in this paragraph who obtains coverage through a guaranteed association. Employees of employers purchasing through a guaranteed association shall be deemed to be eligible employees if they would otherwise meet the definition except for the number of persons employed by the employer.

(2) Any member of a guaranteed association as defined in subdivision (o).

(c) ‘‘In force business’’ means an existing health benefit plan contract issued by the plan to a small employer.

(d) ‘‘Late enrollee’’ means an eligible employee or dependent who has declined enrollment in a health benefit plan offered by a small employer at the time of the initial enrollment period provided under the terms of the health benefit plan and who subsequently requests enrollment in a health benefit plan of that small employer, provided that the initial enrollment period shall be a period of at least 30 days. It also means any member of an association that is a guaranteed association as well as any other person eligible to purchase through the guaranteed association when that person has failed to purchase coverage during the initial enrollment period provided under the terms of the guaranteed association’s plan contract and who subsequently requests enrollment in the plan, provided that the initial enrollment period shall be a period of at least 30 days. However, an eligible employee, any other person eligible for coverage through a guaranteed association pursuant to subdivision (o), or dependent shall not be considered a late enrollee if: (1) the individual meets all of the following: (A) he or she was covered under another employer health benefit plan at the time the individual was eligible to enroll; (B) he or she certified at the time of the initial enrollment that coverage under another employer health benefit plan was the reason for declining enrollment, provided that, if the individual was covered under another employer health plan, the individual was given the opportunity to make the certification required by this subdivision and was notified that failure to do so could result in later treatment as a late enrollee; (C) he or she has lost or will lose coverage under another employer health benefit plan as a result of termination of employment of the individual or of a person through whom the individual was covered as a dependent, change in employment status of the individual or of a person through whom the individual was covered as a dependent, termination of the other plan’s coverage, cessation of an employer’s

contribution toward an employee or dependent's coverage, death of the person through whom the individual was covered as a dependent, or divorce; and (D) he or she requests enrollment within 30 days after termination of coverage or employer contribution toward coverage provided under another employer health benefit plan; (2) the employer offers multiple health benefit plans and the employee elects a different plan during an open enrollment period; (3) a court has ordered that coverage be provided for a spouse or minor child under a covered employee's health benefit plan; (4) (A) in the case of an eligible employee as defined in paragraph (1) of subdivision (b), the plan cannot produce a written statement from the employer stating that the individual or the person through whom the individual was eligible to be covered as a dependent, prior to declining coverage, was provided with, and signed, acknowledgment of an explicit written notice in bold type specifying that failure to elect coverage during the initial enrollment period permits the plan to impose, at the time of the individual's later decision to elect coverage, an exclusion from coverage for a period of 12 months as well as a six-month preexisting condition exclusion, unless the individual meets the criteria specified in paragraph (1), (2), or (3); (B) in the case of an association member who did not purchase coverage through a guaranteed association, the plan cannot produce a written statement from the association stating that the association sent a written notice in bold type to all potentially eligible association members at their last known address prior to the initial enrollment period informing members that failure to elect coverage during the initial enrollment period permits the plan to impose, at the time of the member's later decision to elect coverage, an exclusion from coverage for a period of 12 months as well as a six-month preexisting condition exclusion unless the member can demonstrate that he or she meets the requirements of subparagraphs (A), (C), and (D) of paragraph (1) or paragraph (2) or (3); or (C) in the case of an employer or person who is not a member

of an association, was eligible to purchase coverage through a guaranteed association, and did not do so, and would not be eligible to purchase guaranteed coverage unless purchased through a guaranteed association, the employer or person can demonstrate that he or she meets the requirements of subparagraphs (A), (C), and (D) of paragraph (1), or paragraph (2) or (3), or that he or she recently had a change in status that would make him or her eligible and that application for enrollment was made within 30 days of the change.

(e) ''New business'' means a health care service plan contract issued to a small employer that is not the plan's in force business.

(f) ''Preexisting condition provision'' means a contract provision that excludes coverage for charges or expenses incurred during a specified period following the employee's effective date of coverage, as to a condition for which medical advice, diagnosis, care, or treatment was recommended or received during a specified period immediately preceding the effective date of coverage.

(g) ''Qualifying prior coverage'' means:

(1) Any individual or group policy, contract, or program that is written or administered by a disability insurer, nonprofit hospital service plan, health care service plan, fraternal benefits society, self-insured employer plan, or any other entity, in this state or elsewhere, and that arranges or provides medical, hospital, and surgical coverage not designed to supplement other private or governmental plans. The term includes continuation or conversion coverage but does not include accident only, credit, disability income, Medicare supplement, long-term care, dental, vision, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(2) The federal Medicare program pursuant to Title XVIII of the Social Security Act.

(3) The medicaid program pursuant to Title XIX of the Social Security Act.

(4) Any other publicly sponsored program, provided in this state or elsewhere, of medical, hospital, and surgical care.

(h) ''Rating period'' means the period for which premium rates established by a plan are in effect, and shall be no less than six months.

(i) ''Risk adjusted employee risk rate'' means the rate determined for an eligible employee of a small employer in a particular risk category after applying the risk adjustment factor.

(j) ''Risk adjustment factor'' means the percentage adjustment to be applied equally to each standard employee risk rate for a particular small employer, based upon any expected deviations from standard cost of services. This factor may not be more than 120 percent or less than 80 percent until July 1, 1996. Effective July 1, 1996, this factor may not be more than 110 percent or less than 90 percent.

(k) ''Risk category'' means the following characteristics of an eligible employee: age, geographic region, and family composition of the employee, plus the health benefit plan selected by the small employer.

(1) No more than the following age categories may be used in determining premium rates:

Under 30
30–39
40–49
50–54
55–59
60–64
65 and over

However, for the 65 and over age category, separate premium rates may be specified depending upon whether coverage under the plan contract will be primary or secondary to benefits provided by the federal

Medicare program pursuant to Title XVIII of the federal Social Security Act.

(2) Small employer health care service plans shall base rates to small employers using no more than the following family size categories:

(A) Single.

(B) Married couple.

(C) One adult and child or children.

(D) Married couple and child or children.

(3) (A) In determining rates for small employers, a plan that operates statewide shall use no more than nine geographic regions in the state, have no region smaller than an area in which the first three digits of all its ZIP Codes are in common within a county, and divide no county into more than two regions. Plans shall be deemed to be operating statewide if their coverage area includes 90 percent or more of the state's population. Geographic regions established pursuant to this section shall, as a group, cover the entire state, and the area encompassed in a geographic region shall be separate and distinct from areas encompassed in other geographic regions. Geographic regions may be noncontiguous.

(B) In determining rates for small employers, a plan that does not operate statewide shall use no more than the number of geographic regions in the state than is determined by the following formula: the population, as determined in the last federal census, of all counties that are included in their entirety in a plan's service are divided by the total population of the state, as determined in the last federal census, multiplied by nine. The resulting number shall be rounded to the nearest whole integer. No region may be smaller than an area in which the first three digits of all its ZIP Codes are in common within a county and no county may be divided into more than two regions. The area encompassed in a geographic region shall be separate and distinct from areas encompassed in other geographic regions. Geographic regions may be noncontiguous. No plan shall have less than one geographic area.

Nothing in this section shall be construed to require a plan to establish a new service area or to offer health coverage on a statewide basis, outside of the plan's existing service area.

(*l*) ''Small employer'' means either of the following:

(1) Any person, firm, proprietary or nonprofit corporation, partnership, public agency, or association that is actively engaged in business or service, that, on at least 50 percent of its working days during the preceding calendar quarter, employed at least three, but no more than 50, eligible employees, the majority of whom were employed within this state, that was not formed primarily for purposes of buying health care service plan contracts, and in which a bona fide employer-employee relationship exists. However, for purposes of subdivisions (a), (b), and (c) of Section 1357.03, the definition shall include employers with at least five eligible employees until July 1, 1994, four eligible employees until July 1, 1995, and three eligible employees thereafter. In determining the number of eligible employees, companies that are affiliated companies and that are eligible to file a combined tax return for purposes of state taxation shall be considered one employer. Subsequent to the issuance of a health care service plan contract to a small employer pursuant to this article, and for the purpose of determining eligibility, the size of a small employer shall be determined annually. Except as otherwise specifically provided in this article, provisions of this article that apply to a small employer shall continue to apply until the plan contract anniversary following the date the employer no longer meets the requirements of this definition. It includes any small employer as defined in this paragraph who purchases coverage through a guaranteed association, and any employer purchasing coverage for employees through a guaranteed association.

(2) Any guaranteed association, as defined in subdivision (n), that purchases health coverage for members of the association.

(m) ‘‘Standard employee risk rate’’ means the rate applicable to an eligible employee in a particular risk category in a small employer group.

(n) ‘‘Guaranteed association’’ means a nonprofit organization comprised of a group of individuals or employers who associate based solely on participation in a specified profession or industry, accepting for membership any individual or employer meeting its membership criteria, and that (1) includes one or more small employers as defined in paragraph (1) of subdivision (*l*), (2) does not condition membership directly or indirectly on the health or claims history of any person, (3) uses membership dues solely for and in consideration of the membership and membership benefits, except that the amount of the dues shall not depend on whether the member applies for or purchases insurance offered to the association, (4) is organized and maintained in good faith for purposes unrelated to insurance, (5) has been in active existence on January 1, 1992, and for at least five years prior to that date, (6) has included health insurance as a membership benefit for at least five years prior to January 1, 1992, (7) has a constitution and bylaws, or other analogous governing documents that provide for election of the governing board of the association by its members, (8) offers any plan contract that is purchased to all individual members and employer members in this state, (9) includes any member choosing to enroll in the plan contracts offered to the association provided that the member has agreed to make the required premium payments, and (10) covers at least 1,000 persons with the health care service plan with which it contracts. The requirement of 1,000 persons may be met if component chapters of a statewide association contracting separately with the same carrier cover at least 1,000 persons in the aggregate.

This subdivision applies regardless of whether a contract issued by a plan is with an association or a trust formed for, or sponsored by, an association to administer benefits for association members.

For purposes of this subdivision, an association formed by a merger of two or more associations after January 1, 1992, and otherwise meeting the criteria of this subdivision shall be deemed to have been in active existence on January 1, 1992, if its predecessor organizations had been in active existence on January 1, 1992, and for at least five years prior to that date and otherwise met the criteria of this subdivision.

(o) ''Members of a guaranteed association'' means any individual or employer meeting the association's membership criteria if that person is a member of the association and chooses to purchase health coverage through the association. At the association's discretion, it also may include employees of association members, association staff, retired members, retired employees of members, and surviving spouses and dependents of deceased members. However, if an association chooses to include these persons as members of the guaranteed association, the association shall make that election in advance of purchasing a plan contract. Health care service plans may require an association to adhere to the membership composition it selects for up to 12 months.

SEC. 16.5. Section 1357 of the Health and Safety Code is amended to read:

1357. As used in this article:

(a) ''Dependent'' means the spouse or child of an eligible employee, subject to applicable terms of the health care plan contract covering the employee, and includes dependents of guaranteed association members if the association elects to include dependents under its health coverage at the same time it determines its membership composition pursuant to subdivision (o).

(b) ''Eligible employee'' means either of the following:

(1) Any permanent employee who is actively engaged on a full-time basis in the conduct of the business of the small employer with a normal workweek of at least 30 hours, at the small employer's regular places of business, who has met any statutorily authorized applicable waiting period requirements. The term includes sole proprietors or partners of a partnership, if they are

actively engaged on a full-time basis in the small employer's business and included as employees under a health care plan contract of a small employer, but does not include employees who work on a part-time, temporary, or substitute basis. It includes any eligible employee as defined in this paragraph who obtains coverage through a guaranteed association. Employees of employers purchasing through a guaranteed association shall be deemed to be eligible employees if they would otherwise meet the definition except for the number of persons employed by the employer.

(2) Any member of a guaranteed association as defined in subdivision (o).

(c) ''In force business'' means an existing health benefit plan contract issued by the plan to a small employer.

(d) ''Late enrollee'' means an eligible employee or dependent who has declined enrollment in a health benefit plan offered by a small employer at the time of the initial enrollment period provided under the terms of the health benefit plan and who subsequently requests enrollment in a health benefit plan of that small employer, provided that the initial enrollment period shall be a period of at least 30 days. It also means any member of an association that is a guaranteed association as well as any other person eligible to purchase through the guaranteed association when that person has failed to purchase coverage during the initial enrollment period provided under the terms of the guaranteed association's plan contract and who subsequently requests enrollment in the plan, provided that the initial enrollment period shall be a period of at least 30 days. However, an eligible employee, any other person eligible for coverage through a guaranteed association pursuant to subdivision (o), or dependent shall not be considered a late enrollee if: (1) the individual meets all of the following: (A) he or she was covered under another employer health benefit plan at the time the individual was eligible to enroll; (B) he or she certified at the time of the initial enrollment that coverage under another employer health benefit plan

was the reason for declining enrollment, provided that, if the individual was covered under another employer health plan, the individual was given the opportunity to make the certification required by this subdivision and was notified that failure to do so could result in later treatment as a late enrollee; (C) he or she has lost or will lose coverage under another employer health benefit plan as a result of termination of employment of the individual or of a person through whom the individual was covered as a dependent, change in employment status of the individual or of a person through whom the individual was covered as a dependent, termination of the other plan's coverage, cessation of an employer's contribution toward an employee or dependent's coverage, death of the person through whom the individual was covered as a dependent, or divorce; and (D) he or she requests enrollment within 30 days after termination of coverage or employer contribution toward coverage provided under another employer health benefit plan; (2) the employer offers multiple health benefit plans and the employee elects a different plan during an open enrollment period; (3) a court has ordered that coverage be provided for a spouse or minor child under a covered employee's health benefit plan; (4) (A) in the case of an eligible employee as defined in paragraph (1) of subdivision (b), the plan cannot produce a written statement from the employer stating that the individual or the person through whom the individual was eligible to be covered as a dependent, prior to declining coverage, was provided with, and signed, acknowledgment of an explicit written notice in bold type specifying that failure to elect coverage during the initial enrollment period permits the plan to impose, at the time of the individual's later decision to elect coverage, an exclusion from coverage for a period of 12 months as well as a six-month preexisting condition exclusion, unless the individual meets the criteria specified in paragraph (1), (2), or (3); (B) in the case of an association member who did not purchase coverage through a guaranteed association, the plan cannot

produce a written statement from the association stating that the association sent a written notice in bold type to all potentially eligible association members at their last known address prior to the initial enrollment period informing members that failure to elect coverage during the initial enrollment period permits the plan to impose, at the time of the member's later decision to elect coverage, an exclusion from coverage for a period of 12 months as well as a six-month preexisting condition exclusion unless the member can demonstrate that he or she meets the requirements of subparagraphs (A), (C), and (D) of paragraph (1) or paragraph (2) or (3); or (C) in the case of an employer or person who is not a member of an association, was eligible to purchase coverage through a guaranteed association, and did not do so, and would not be eligible to purchase guaranteed coverage unless purchased through a guaranteed association, the employer or person can demonstrate that he or she meets the requirements of subparagraphs (A), (C), and (D) of paragraph (1), or paragraph (2) or (3), or that he or she recently had a change in status that would make him or her eligible and that application for enrollment was made within 30 days of the change.

(e) ''New business'' means a health care service plan contract issued to a small employer that is not the plan's in force business.

(f) ''Preexisting condition provision'' means a contract provision that excludes coverage for charges or expenses incurred during a specified period following the employee's effective date of coverage, as to a condition for which medical advice, diagnosis, care, or treatment was recommended or received during a specified period immediately preceding the effective date of coverage.

(g) ''Qualifying prior coverage'' means:

(1) Any individual or group policy, contract, or program that is written or administered by a disability insurer, nonprofit hospital service plan, health care service plan, fraternal benefits society, self-insured employer plan, or any other entity, in this state or elsewhere, and that arranges or provides medical,

hospital, and surgical coverage not designed to supplement other private or governmental plans. The term includes continuation or conversion coverage but does not include accident only, credit, disability income, Medicare supplement, long-term care, dental, vision, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(2) The federal Medicare program pursuant to Title XVIII of the Social Security Act.

(3) The medicaid program pursuant to Title XIX of the Social Security Act.

(4) Any other publicly sponsored program, provided in this state or elsewhere, of medical, hospital, and surgical care.

(h) ''Rating period'' means the period for which premium rates established by a plan are in effect, and shall be no less than six months.

(i) ''Risk adjusted employee risk rate'' means the rate determined for an eligible employee of a small employer in a particular risk category after applying the risk adjustment factor.

(j) ''Risk adjustment factor'' means the percentage adjustment to be applied equally to each standard employee risk rate for a particular small employer, based upon any expected deviations from standard cost of services. This factor may not be more than 120 percent or less than 80 percent until July 1, 1996. Effective July 1, 1996, this factor may not be more than 110 percent or less than 90 percent.

(k) ''Risk category'' means the following characteristics of an eligible employee: age, geographic region, and family composition of the employee, plus the health benefit plan selected by the small employer.

(1) No more than the following age categories may be used in determining premium rates:

Under 30
30–39
40–49
50–54
55–59
60–64
65 and over

However, for the 65 and over age category, separate premium rates may be specified depending upon whether coverage under the plan contract will be primary or secondary to benefits provided by the federal Medicare program pursuant to Title XVIII of the federal Social Security Act.

(2) Small employer health care service plans shall base rates to small employers using no more than the following family size categories:

(A) Single.

(B) Married couple.

(C) One adult and child or children.

(D) Married couple and child or children.

(3) (A) In determining rates for small employers, a plan that operates statewide shall use no more than nine geographic regions in the state, have no region smaller than an area in which the first three digits of all its ZIP Codes are in common within a county, and divide no county into more than two regions. Plans shall be deemed to be operating statewide if their coverage area includes 90 percent or more of the state's population. Geographic regions established pursuant to this section shall, as a group, cover the entire state, and the area encompassed in a geographic region shall be separate and distinct from areas encompassed in other geographic regions. Geographic regions may be noncontiguous.

(B) In determining rates for small employers, a plan that does not operate statewide shall use no more than the number of geographic regions in the state than is determined by the following formula: the population, as determined in the last federal census, of all counties that are included in their entirety in a plan's service are divided by the total population of the state, as determined

in the last federal census, multiplied by nine. The resulting number shall be rounded to the nearest whole integer. No region may be smaller than an area in which the first three digits of all its ZIP Codes are in common within a county and no county may be divided into more than two regions. The area encompassed in a geographic region shall be separate and distinct from areas encompassed in other geographic regions. Geographic regions may be noncontiguous. No plan shall have less than one geographic area.

Nothing in this section shall be construed to require a plan to establish a new service area or to offer health coverage on a statewide basis, outside of the plan's existing service area.

(*l*) ''Small employer'' means either of the following:

(1) Any person, firm, proprietary or nonprofit corporation, partnership, public agency, or association that is actively engaged in business or service, that, on at least 50 percent of its working days during the preceding calendar quarter, employed at least two, but no more than 50, eligible employees, the majority of whom were employed within this state, that was not formed primarily for purposes of buying health care service plan contracts, and in which a bona fide employer-employee relationship exists. However, for purposes of subdivisions (a), (b), and (c) of Section 1357.03, the definition shall include employers with at least three eligible employees until July 1, 1997, and two eligible employees thereafter. In determining the number of eligible employees, companies that are affiliated companies and that are eligible to file a combined tax return for purposes of state taxation shall be considered one employer. Subsequent to the issuance of a health care service plan contract to a small employer pursuant to this article, and for the purpose of determining eligibility, the size of a small employer shall be determined annually. Except as otherwise specifically provided in this article, provisions of this article that apply to a small employer shall continue to apply until the plan contract anniversary following the date the employer no longer meets the requirements of

this definition. It includes any small employer as defined in this paragraph who purchases coverage through a guaranteed association, and any employer purchasing coverage for employees through a guaranteed association.

(2) Any guaranteed association, as defined in subdivision (n), that purchases health coverage for members of the association.

(m) ''Standard employee risk rate'' means the rate applicable to an eligible employee in a particular risk category in a small employer group.

(n) ''Guaranteed association'' means a nonprofit organization comprised of a group of individuals or employers who associate based solely on participation in a specified profession or industry, accepting for membership any individual or employer meeting its membership criteria, and that (1) includes one or more small employers as defined in paragraph (1) of subdivision (*l*), (2) does not condition membership directly or indirectly on the health or claims history of any person, (3) uses membership dues solely for and in consideration of the membership and membership benefits, except that the amount of the dues shall not depend on whether the member applies for or purchases insurance offered to the association, (4) is organized and maintained in good faith for purposes unrelated to insurance, (5) has been in active existence on January 1, 1992, and for at least five years prior to that date, (6) has included health insurance as a membership benefit for at least five years prior to January 1, 1992, (7) has a constitution and bylaws, or other analogous governing documents that provide for election of the governing board of the association by its members, (8) offers any plan contract that is purchased to all individual members and employer members in this state, (9) includes any member choosing to enroll in the plan contracts offered to the association provided that the member has agreed to make the required premium payments, and (10) covers at least 1,000 persons with the health care service plan with which it contracts. The requirement of 1,000

persons may be met if component chapters of a statewide association contracting separately with the same carrier cover at least 1,000 persons in the aggregate.

This subdivision applies regardless of whether a contract issued by a plan is with an association or a trust formed for, or sponsored by, an association to administer benefits for association members.

For purposes of this subdivision, an association formed by a merger of two or more associations after January 1, 1992, and otherwise meeting the criteria of this subdivision shall be deemed to have been in active existence on January 1, 1992, if its predecessor organizations had been in active existence on January 1, 1992, and for at least five years prior to that date and otherwise met the criteria of this subdivision.

(o) ''Members of a guaranteed association'' means any individual or employer meeting the association's membership criteria if that person is a member of the association and chooses to purchase health coverage through the association. At the association's discretion, it also may include employees of association members, association staff, retired members, retired employees of members, and surviving spouses and dependents of deceased members. However, if an association chooses to include these persons as members of the guaranteed association, the association shall make that election in advance of purchasing a plan contract. Health care service plans may require an association to adhere to the membership composition it selects for up to 12 months.

SEC. 17. Section 1357.50 of the Health and Safety Code is amended to read:

1357.50. For purposes of this article:

(a) ''Health benefit plan'' means any individual or group, insurance policy or health care service plan contract, that provides medical, hospital, and surgical benefits. The term does not include accident only, credit, disability income, coverage of Medicare services pursuant to contracts with the United States government, Medicare supplement, long-term care insurance, dental, vision, coverage issued as a supplement to liability

insurance, insurance arising out of a workers' compensation or similar law, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(b) ''Late enrollee'' means an eligible employee or dependent who has declined health coverage under a health benefit plan offered through employment or sponsored by an employer at the time of the initial enrollment period provided under the terms of the health benefit plan, and who subsequently requests enrollment in a health benefit plan of that employer; provided that the initial enrollment period shall be a period of at least 30 days. However, an eligible employee or dependent shall not be considered a late enrollee if any of the following is applicable:

(1) The individual meets all of the following requirements:

(A) The individual was covered under another employer health benefit plan at the time the individual was eligible to enroll.

(B) The individual certified, at the time of the initial enrollment that coverage under another employer health benefit plan was the reason for declining enrollment provided that, if the individual was covered under another employer health plan, the individual was given the opportunity to make the certification required by this subdivision and was notified that failure to do so could result in later treatment as a late enrollee.

(C) The individual has lost or will lose coverage under another employer health benefit plan as a result of termination of employment of the individual or of a person through whom the individual was covered as a dependent, change in employment status of the individual or of a person through whom the individual was covered as a dependent, termination of the other plan's coverage, cessation of an employer's contribution toward an employee or dependent's coverage, death of a

person through whom the individual was covered as a dependent, or divorce.

(D) The individual requests enrollment within 30 days after termination of coverage, or cessation of employer contribution toward coverage provided under another employer health benefit plan.

(2) The individual is employed by an employer that offers multiple health benefit plans and the individual elects a different plan during an open enrollment period.

(3) A court has ordered that coverage be provided for a spouse or minor child under a covered employee's health benefit plan. The health benefits plan shall enroll a dependent child within 30 days after receipt of a court order or request from the district attorney, either parent or the person having custody of the child as defined in Section 3751.5 of the Family Code, the employer, or the group administrator. In the case of children who are eligible for medicaid, the State Department of Health Services may also make the request.

(4) The plan cannot produce a written statement from the employer stating that, prior to declining coverage, the individual or the person through whom the individual was eligible to be covered as a dependent was provided with, and signed acknowledgment of, explicit written notice in bold type specifying that failure to elect coverage during the initial enrollment period permits the plan to impose, at the time of the individual's later decision to elect coverage, an exclusion from coverage for a period of 12 months as well as a six-month preexisting condition exclusion, unless the individual meets the criteria specified in paragraph (1), (2), or (3).

(c) ''Preexisting condition provision'' means a contract provision that excludes coverage for charges or expenses incurred during a specified period following the enrollee's effective date of coverage, as to a condition for which medical advice, diagnosis, care, or treatment was recommended or received during a specified period immediately preceding the effective date of coverage.

(d) ''Qualifying prior coverage'' means:

(1) Any individual or group policy, contract or program, that is written or administered by a disability insurance company, nonprofit hospital service plan, health care service plan, fraternal benefits society, self-insured employer plan, or any other entity, in this state or elsewhere, and that arranges or provides medical, hospital and surgical coverage not designed to supplement other private or governmental plans. The term includes continuation or conversion coverage but does not include accident only, credit, disability income, Medicare supplement, long-term care insurance, dental, vision, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(2) The federal Medicare program pursuant to Title XVIII of the Social Security Act.

(3) The medicaid program pursuant to Title XIX of the Social Security Act.

(4) Any other publicly sponsored program, provided in this state or elsewhere, of medical, hospital and surgical care.

(e) ''Waivered condition'' means a contract provision that excludes coverage for charges or expenses incurred during a specified period of time for one or more specific, identified, medical conditions.

SEC. 18. Section 1374.3 of the Health and Safety Code is amended to read:

1374.3. Notwithstanding any other provision of this chapter or of a health care service plan contract, every health care service plan shall comply with the requirements of Chapter 7 (commencing with Section 3750) of Part 1 of Division 9 of the Family Code and Section 14124.94 of the Welfare and Institutions Code.

SEC. 19. Section 102425 of the Health and Safety Code is amended to read:

102425. (a) The certificate of live birth for any live birth occurring on or after January 1, 1980, shall contain those items necessary to establish the fact of the birth and shall contain only the following information:

(1) Full name and sex of child.

(2) Date of birth, including month, day, hour, and year.

(3) Planned place of birth and place of birth.

(4) Full name of father, birthplace, and date of birth of father including month, day, and year. If the parents are not married to each other, the father's name shall not be listed on the birth certificate unless the father and the mother sign a voluntary declaration of paternity at the hospital before the birth certificate is prepared. The birth certificate may be amended to add the father's name at a later date only if paternity for the child has been established by a judgment of a court of competent jurisdiction or by the filing of a voluntary declaration of paternity.

(5) Full birth name of mother, birthplace, and date of birth of mother including month, day, and year.

(6) Multiple births and birth order of multiple births.

(7) Signature, and relationship to child, of a parent or other informant, and date signed.

(8) Name, title, and mailing address of attending physician and surgeon or principal attendant, signature, and certification of live birth by attending physician and surgeon or principal attendant or certifier, date signed, and name and title of certifier if other than attending physician and surgeon or principal attendant.

(9) Date accepted for registration and signature of local registrar.

(10) A state birth certificate number and local registration district and number.

(11) A blank space for entry of date of death with a caption reading ''Date of Death.''

(b) In addition to the items listed in subdivision (a), the certificate of live birth shall contain the following medical and social information, provided that the information is kept confidential pursuant to Sections

102430 and 102447 and is clearly labeled ‘‘Confidential Information for Public Health Use Only:’’

(1) Birth weight.

(2) Pregnancy history.

(3) Race and ethnicity of mother and father.

(4) Residence address of mother.

(5) A blank space for entry of census tract for mother’s address.

(6) Month prenatal care began and number of prenatal visits.

(7) Date of last normal menses.

(8) Description of complications of pregnancy and concurrent illnesses, congenital malformation, and any complication of labor and delivery, including surgery; provided that this information is essential medical information and appears in total on the face of the certificate.

(9) Mother’s and father’s occupations and kind of business or industry.

(10) Education level of mother and father.

(11) Principal source of pay for prenatal care, which shall include all of the following: Medi-Cal, health maintenance organization or prepaid health plan, private insurance companies, medically indigent, self-pay, other sources which shall include, Medicare, workers’ compensation, Title V, other government or nongovernment programs, no charge, and other categories as determined by the State Department of Health Services.

This paragraph shall become inoperative on January 1, 1999, or on the implementation date of the decennial birth certificate revision due to occur on or about January 1, 1999, whichever occurs first.

(12) Expected principal source of pay for delivery, which shall include all of the following: Medi-Cal, health maintenance organization or prepaid health plan, private insurance companies, medically indigent, self-pay, other sources which shall include, Medicare, workers’ compensation, Title V, other government or nongovernment programs, no charge, and other

categories as determined by the State Department of Health Services.

This paragraph shall become inoperative on January 1, 1999, or on the implementation date of the decennial birth certificate revision due to occur on or about January 1, 1999, whichever occurs first.

(13) An indication of whether or not the child's parent desires the automatic issuance of a Social Security number to the child.

(14) On and after January 1, 1995, the Social Security numbers of the mother and father, unless subdivision (b) of Section 102150 applies.

(c) Item 8, specified in subdivision (b), shall be completed by the attending physician and surgeon or the attending physician's and surgeon's designated representative. The names and addresses of children born with congenital malformations, who require followup treatment, as determined by the child's physician and surgeon, shall be furnished by the physician and surgeon to the local health officer, if permission is granted by either parent of the child.

(d) The parent shall only be asked to sign the form after both the public portion and the confidential medical and social information items have been entered upon the certificate of live birth.

(e) The State Registrar shall instruct all local registrars to collect the information specified in this section with respect to certificates of live birth. The information shall be transcribed on the certificate of live birth in use at the time and shall be limited to the information specified in this section.

Information relating to concurrent illnesses, complications of pregnancy and delivery, and congenital malformations shall be completed by the physician and surgeon, or physician's and surgeon's designee, inserting in the space provided on the confidential portion of the certificate the appropriate number or numbers listed on the VS-10A supplemental worksheet. The VS-10A supplemental form shall be used as a worksheet only and shall not in any manner be linked with the identity of the

child or the mother, nor submitted with the certificate to the State Registrar. All information transferred from the worksheet to the certificate shall be fully explained to the parent or other informant prior to the signing of the certificate. No questions relating to drug or alcohol abuse may be asked.

(f) If the implementation date of the decennial birth certificate revision occurs prior to January 1, 1999, within 30 days of this implementation date the State Department of Health Services shall file a letter with the Secretary of the Senate and with the Chief Clerk of the Assembly, so certifying.

SEC. 19.5. Article 4 (commencing with Section 102766) is added to Chapter 5 of Part 1 of Division 102 of the Health and Safety Code, to read:

Article 4. Voluntary Declaration of Paternity

102766. (a) When a voluntary declaration of paternity is filed with the State Registrar pursuant to subdivision (d) of Section 7571 of the Family Code, an application may be submitted to the State Registrar requesting that the father's name be added to the child's birth certificate.

(b) Upon receipt of the application and payment of the required fee, the State Registrar shall review the application for acceptance for filing, and if accepted, shall establish a new birth certificate for the child in the manner prescribed in Article 1 (commencing with Section 102625), if the original record of birth is on file in the office of the State Registrar.

102767. (a) When a voluntary declaration of paternity is rescinded pursuant to subdivision (a) of Section 7575 of the Family Code, an application may be submitted to the State Registrar requesting that the father's name be removed from the child's birth certificate.

(b) Upon receipt of the application and payment of the required fee, the State Registrar shall establish a new birth certificate for the child in the manner prescribed in

Article 1 (commencing with Section 102625), if the original record of birth is on file in the office of the State Registrar.

102768. All records and information specified in this article, other than the newly established certificate, shall be available only to those persons specified in subdivision (h) of Section 7571 of the Family Code or upon order of a court of record.

102769. The State Registrar shall furnish a certified copy of the new record of birth prepared under authority of this article to the registrant without additional cost.

SEC. 20. Section 10119 of the Insurance Code is amended to read:

10119. On and after the operative date of this section:

(a) No policy of disability insurance which, in addition to covering the insured, also covers members of the insured's immediate family, may be issued or amended in this state if it contains any disclaimer, waiver, or other limitation of coverage relative to the accident and sickness coverage or insurability of newborn infants of an insured from and after the moment of birth or of any minor child placed with an insured for adoption from and after the moment the child is placed in the physical custody of the insured for adoption.

(b) Each such policy of disability insurance shall contain a provision granting immediate accident and sickness coverage to each newborn infant of, and each minor child placed for adoption with, any insured as required by subdivision (a).

(c) A policy of disability insurance, self-insured care coverage, employee welfare benefit plan, or nonprofit hospital service plan, shall comply with the standards set forth in Chapter 7 (commencing with Section 3750) of Part 1 of Division 9 of the Family Code and Section 14124.94 of the Welfare and Institutions Code.

SEC. 21. Section 10121.6 of the Insurance Code is amended to read:

10121.6. (a) No policy of group disability insurance or self-insured employee welfare benefit plan which provides hospital, medical, or surgical expense benefits

for employees, insureds, or policyholders and their dependents shall exclude a dependent child from eligibility or benefits solely because the dependent child does not reside with the employee, insured, or policyholder.

(b) Each policy of group disability insurance or self-insured employee welfare benefit plan which provides hospital, medical, or surgical expense benefits for employees, insureds, or policyholders and their dependents shall enroll, upon application by the employer or group administrator, a dependent child of the noncustodial parent when that parent is the employee, insured, or policyholder at any time either the parent or the person having custody of the child as defined in Section 3751.5 of the Family Code, or the district attorney makes an application for enrollment to the employer or group administrator when a court order for medical support exists. In the case of children who are eligible for medicaid, the State Department of Health Services may also make that application.

SEC. 22. Section 10198.6 of the Insurance Code is amended to read:

10198.6. For purposes of this article:

(a) ''Health benefit plan'' means any group or individual policy or contract that provides medical, hospital, and surgical benefits. The term does not include accident only, credit, disability income, coverage of Medicare services pursuant to contracts with the United States government, Medicare supplement, long-term care insurance, dental, vision, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(b) ''Late enrollee'' means an eligible employee or dependent who has declined health coverage under a health benefit plan offered through employment or sponsored by an employer at the time of the initial

enrollment period provided under the terms of the health benefit plan, and who subsequently requests enrollment in a health benefit plan of that employer; provided that the initial enrollment period shall be a period of at least 30 days. However, an eligible employee or dependent shall not be considered a late enrollee if any of the following is applicable:

(1) The individual meets all of the following requirements:

(A) The individual was covered under another employer health benefit plan at the time the individual was eligible to enroll.

(B) The individual certified, at the time of the initial enrollment that coverage under another employer health benefit plan was the reason for declining enrollment provided that, if the individual was covered under another employer health plan, the individual was given the opportunity to make the certification required by this subdivision and was notified that failure to do so could result in later treatment as a late enrollee.

(C) The individual has lost or will lose coverage under another employer health benefit plan as a result of termination of employment of the individual or of a person through whom the individual was covered as a dependent, change in employment status of the individual or of a person through whom the individual was covered as a dependent, termination of the other plan’s coverage, cessation of an employer’s contribution toward an employee or dependent’s coverage, death of a person through whom the individual was covered as a dependent, or divorce.

(D) The individual requests enrollment within 30 days after termination of coverage, or cessation of employer contribution toward coverage provided under another employer health benefit plan.

(2) The individual is employed by an employer that offers multiple health benefit plans and the individual elects a different plan during an open enrollment period.

(3) A court has ordered that coverage be provided for a spouse or minor child under a covered employee's health benefit plan.

(4) The carrier cannot produce a written statement from the employer stating that, prior to declining coverage, the individual or the person through whom the individual was eligible to be covered as a dependent was provided with, and signed acknowledgment of, explicit written notice in bold type specifying that failure to elect coverage during the initial enrollment period permits the carrier to impose, at the time of the individual's later decision to elect coverage, an exclusion from coverage for a period of 12 months as well as a six month preexisting condition exclusion, unless the individual meets the criteria specified in paragraph (1), (2), or (3).

(c) ''Preexisting condition provision'' means a policy provision that excludes coverage for charges or expenses incurred during a specified period following the insured's effective date of coverage, as to a condition for which medical advice, diagnosis, care, or treatment was recommended or received during a specified period immediately preceding the effective date of coverage.

(d) ''Qualifying prior coverage'' means:

(1) Any individual or group policy, contract or program, that is written or administered by a disability insurance company, nonprofit hospital service plan, health care service plan, fraternal benefits society, self-insured employer plan, or any other entity, in this state or elsewhere, and that arranges or provides medical, hospital, and surgical coverage not designed to supplement other private or governmental plans. The term includes continuation or conversion coverage but does not include accident only, credit, disability income, Medicare supplement, long-term care insurance, dental, vision, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and that is

statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(2) The federal Medicare program pursuant to Title XVIII of the Social Security Act.

(3) The medicaid program pursuant to Title XIX of the Social Security Act.

(4) Any other publicly sponsored program, provided in this state or elsewhere, of medical, hospital and surgical care.

SEC. 23. Section 10702.1 of the Insurance Code is amended to read:

10702.1. Any person or entity subject to the requirements of this chapter shall comply with the standards set forth in Chapter 7 (commencing with Section 3750) of Part 1 of Division 9 of the Family Code and Section 14124.94 of the Welfare and Institutions Code.

SEC. 24. Section 10711 of the Insurance Code is amended to read:

10711. No carrier shall be required by the provisions of this chapter:

(a) To offer coverage to, or accept applications from, a small employer as defined in paragraph (1) of subdivision (w) of Section 10700, where the small employer is not physically located in a carrier's approved service areas.

(b) To offer coverage to or accept applications from a small employer as defined in paragraph (2) of subdivision (w) of Section 10700 where the small employer is seeking coverage for eligible employees who do not work or reside in a carrier's approved service areas.

(c) To include in a health benefits plan an otherwise eligible employee or dependent, when the eligible employee or dependent does not work or reside within a carrier's approved service area, except as provided in Section 10702.1.

(d) To offer coverage to, or accept applications from, a small employer for a benefits plan design within an area if the commissioner has found that the carrier will not have the capacity within the area in its network of providers to deliver service adequately to the eligible

employees and dependents of that employee because of its obligations to existing group contractholders and enrollees and that the action is not unreasonable or clearly inconsistent with the intent of this chapter.

A carrier that cannot offer coverage to small employers in a specific service area because it is lacking sufficient capacity may not offer coverage in the applicable area to new employer groups with more than 50 eligible employees until the carrier notifies the commissioner that it has regained capacity to deliver services to small employers, and certifies to the commissioner that from the date of the notice it will enroll all small groups requesting coverage from the carrier until the carrier has met the requirements of subdivision (h) of Section 10705.

(e) To offer coverage to a small employer, or an eligible employee as defined in paragraph (2) of subdivision (g) of Section 10700, who within 12 months of application for coverage terminated from a health benefit plan offered by the carrier.

SEC. 25. Section 10719.1 of the Insurance Code is amended to read:

10719.1. Any person or entity subject to the requirements of this chapter shall comply with the standards set forth in Chapter 7 (commencing with Section 3750) of Part 1 of Division 9 of the Family Code and Section 14124.94 of the Welfare and Institutions Code.

SEC. 26. Section 10731.2 of the Insurance Code is amended to read:

10731.2. Any person or entity subject to the requirements of this chapter shall comply with the standards set forth in Chapter 7 (commencing with Section 3750) of Part 1 of Division 9 of the Family Code and Section 14124.94 of the Welfare and Institutions Code.

SEC. 27. Section 11516.1 of the Insurance Code is amended to read:

11516.1. (a) No group nonprofit hospital service plan which provides hospital, medical, or surgical expense benefits for employees, members, or policyholders and their dependents shall exclude a dependent child from eligibility or benefits solely because the dependent child

does not reside with the employee, member, or policyholder.

(b) A group nonprofit hospital service plan which provides hospital, medical, or surgical expense benefits for employees, members, or policyholders and their dependents shall enroll, upon application by the employer or group administrator, a dependent child of the noncustodial parent when that parent is the employee, member, or policyholder of the plan at any time the either parent or the person having custody of the child as defined in Section 3751.5 of the Family Code, or district attorney makes an application for enrollment to the employer or group administrator when a court order for medical support exists. In the case of children who are eligible for medicaid, the State Department of Health Services may also make that application.

SEC. 28. Section 2803.5 of the Labor Code is amended to read:

2803.5. Any employer who offers health care coverage, including employers and insurers, shall comply with the standards set forth in Chapter 7 (commencing with Section 3750) of Part 1 of Division 9 of the Family Code and Section 14124.94 of the Welfare and Institutions Code.

SEC. 29. Section 11350.3 of the Welfare and Institutions Code is amended to read:

11350.3. In any action filed by the district attorney pursuant to Section 11350 or 11350.1, the district attorney shall provide the mother and the alleged father the opportunity to voluntarily acknowledge paternity by signing a paternity declaration as described in Section 7574 of the Family Code prior to a hearing or trial where the paternity of a minor child is at issue. The opportunity to voluntarily acknowledge paternity may be provided either before or after an action pursuant to Section 11350 or 11350.1 is filed and served upon the alleged father. For the purpose of meeting the requirements of this action, the district attorney may afford the defendant an opportunity to enter into a stipulation for judgment of

paternity after an action for paternity has been filed in lieu of the voluntary declaration of paternity.

SEC. 30. Section 11350.4 of the Welfare and Institutions Code is amended to read:

11350.4. (a) Notwithstanding any other law, an action for child support may be brought by the district attorney on behalf of a minor child or caretaker parent based upon a voluntary declaration of paternity as provided in Chapter 3 (commencing with Section 7570) of Part 2 of Division 12 of the Family Code.

(b) Except as provided in Sections 7576 and 7577 of the Family Code, the voluntary declaration of paternity shall be given the same force and effect as a judgment for paternity entered by a court of competent jurisdiction. The court shall make appropriate orders for support of the minor child based upon the voluntary declaration of paternity unless evidence is presented that the voluntary declaration of paternity has been rescinded by the parties or set aside by a court as provided in Section 7575 of the Family Code.

(c) The Judicial Council shall develop the forms and procedures necessary to implement this section.

SEC. 31. Section 11476 of the Welfare and Institutions Code is amended to read:

11476. It shall be the duty of the county department to refer all cases where a parent is absent from the home, or where the parents are unmarried and parentage has not been established by the completion and filing of a voluntary declaration of paternity pursuant to Section 7573 of the Family Code or a court of competent jurisdiction, to the district attorney immediately at the time the application for public assistance, including Medi-Cal benefits, or certificate of eligibility, is signed by the applicant or recipient. If an applicant is found to be ineligible, the applicant shall be notified in writing that the referral of the case to the district attorney may be terminated at the applicant’s request. The county department shall cooperate with the district attorney and shall make available to him or her all pertinent information as provided in Section 11478.

Upon referral from the county department, the district attorney shall investigate the question of nonsupport or paternity and shall take all steps necessary to obtain child support for the needy child, enforce spousal support as part of the state plan under Section 11475.2, and determine paternity in the case of a child born out of wedlock. Upon the advice of the county department that a child is being considered for adoption, the district attorney shall delay the investigation and other actions with respect to the case until advised that the adoption is no longer under consideration. The granting of public assistance or Medi-Cal benefits to an applicant shall not be delayed or contingent upon investigation by the district attorney.

In cases where Medi-Cal benefits are the only assistance provided, the district attorney shall provide child and spousal support services unless the recipient of the services notifies the district attorney that only services related to securing Medi-Cal benefits are requested.

Where a court order has been obtained, any contractual agreement for support between the district attorney or the county department and the noncustodial parent shall be deemed null and void to the extent that it is not consistent with the court order.

Whenever a family which has been receiving public assistance, including Medi-Cal, ceases to receive assistance, including Medi-Cal, the district attorney shall, to the extent required by federal regulations, continue to enforce support payments from the noncustodial parent until such time as the individual on whose behalf the enforcement efforts are made sends written notice to the district attorney requesting that enforcement services be discontinued.

The district attorney shall, where appropriate, utilize reciprocal arrangements adopted with other states in securing support from an absent parent. In individual cases where utilization of reciprocal arrangements has proven ineffective, the district attorney may forward to the Attorney General a request to utilize federal courts in order to obtain or enforce orders for child or spousal

support. If reasonable efforts to collect amounts assigned pursuant to Section 11477 have failed, the district attorney may request that the case be forwarded to the Treasury Department for collection in accordance with federal regulations. The Attorney General, where appropriate, shall forward these requests to the Secretary of Health and Human Services, or a designated representative.

SEC. 32. Section 11478.8 of the Welfare and Institutions Code is amended to read:

11478.8. (a) Upon receipt of a written request from a district attorney enforcing the obligation of parents to support their children pursuant to Section 11475.1, every employer, as specified in Section 5210 of the Family Code, and every labor organization shall cooperate with and provide relevant employment and income information which they have in their possession to the district attorney for the purpose of establishing, modifying, or enforcing the support obligation. No employer or labor organization shall incur any liability for providing this information to the district attorney.

Relevant employment and income information shall include, but not be limited to, all of the following:

(1) Whether a named person has or has not been employed by an employer or whether a named person has or has not been employed to the knowledge of the labor organization.

(2) The full name of the employee or member or the first and middle initial and last name of the employee or member.

(3) The employee's or member's last known residence address.

(4) The employee's or member's date of birth.

(5) The employee's or member's Social Security number.

(6) The dates of employment.

(7) All earnings paid to the employee or member and reported as W-2 compensation in the prior tax year and the employee's or member's current basic rate of pay.

(8) Other earnings, as specified in Section 5206 of the Family Code, paid to the employee or member.

(9) Whether the dependent health insurance coverage is available to the employee through employment or membership in the labor organization.

The district attorney shall notify the employer and labor organization of the district attorney case file number in making a request pursuant to this section. The written request shall include at least three of the following elements regarding the person who is the subject of the inquiry: (A) first and last name and middle initial, if known; (B) Social Security number; (C) driver's license number; (D) birth date; (E) last known address; or (F) spouse's name.

The district attorney shall send a notice that a request for this information has been made to the last known address of the person who is the subject of the inquiry.

(b) An employer or labor organization which fails to provide relevant employment information to the district attorney within 30 days of receiving a request pursuant to subdivision (a) may be assessed a civil penalty of a maximum of one thousand dollars ($1,000), plus attorneys' fees and costs. Proceedings to impose the civil penalty shall be commenced by the filing and service of an order to show cause.

(c) ''Labor organization,'' for the purposes of this section means a labor organization as defined in Section 1117 of the Labor Code or any related benefit trust fund covered under the federal Employee Retirement Income Security Act of 1974 (Chapter 18 (commencing with Section 1001) of Title 29 of the United States Code).

(d) Any reference to the district attorney in this section shall apply only when the district attorney is otherwise ordered or required to act pursuant to existing law. Nothing in this section shall be deemed to mandate additional enforcement or collection duties upon the district attorney beyond those imposed under existing law on the effective date of this section.

SEC. 33. Section 14124.93 of the Welfare and Institutions Code, as added by Section 24 of Chapter 147 of the Statutes of 1994, is repealed.

SEC. 34. Section 14124.94 is added to the Welfare and Institutions Code, to read:

14124.94. (a) When the rights of a Medi-Cal beneficiary to health care benefits from an insurer have been assigned to the department, an insurer shall not impose any requirement on the department that is different from any requirement applicable to an agent or any assignee of the covered beneficiary.

(b) The department, in the administration of the Medi-Cal program, may garnish the wages, salary, or other employment income of, and withhold amounts from state tax refunds from, any person to whom both of the following apply:

(1) The person is required by a court or administrative order to provide coverage of the costs of health services to a child who is eligible for medical assistance under the Medi-Cal program.

(2) The person has received payment from a third party for the costs of the health services for the child, but he or she has not used the payments to reimburse, as appropriate, either the other parent or the person having custody of the child, or the provider of the health services, to the extent necessary to reimburse the department for expenditures for those costs under the Medi-Cal program. All claims for current or past due child support shall take priority over claims made by the department for the costs of Medi-Cal services.

(c) For purposes of this section, ‘‘insurer’’ includes every health care service plan, self-insured welfare benefit plan, including those regulated pursuant to the Employee Retirement Income Security Act of 1974 (29 U.S.C. Sec. 1001, et. seq.), self-funded employer plan, disability insurer, nonprofit hospital service plan, labor union trust fund, employer, and any other similar plan, insurer, or entity offering a health coverage plan.

SEC. 35. Section 15200.1 of the Welfare and Institutions Code is amended to read:

15200.1. (a) There is hereby appropriated out of any money in the State Treasury not otherwise appropriated, from which the department shall make payments to each county on any support payments collected or distributed, or both, federal incentive funds on the amount received which qualify therefor. In addition, the department shall pay to each county on any support collections distributed, regardless of the date of collection, a state incentive of 7.5 percent. This amount shall be paid on collections used to reduce or repay aid which is paid pursuant to this chapter, on collections paid to an aided family in the form of income which is not included in determining eligibility for assistance pursuant to federal law (also referred to as ''disregards''), on collections paid to an aided family in the form of income which is included in determining eligibility (also referred to as ''pass-ons'' and ''excess''), and for aid which is entitled to federal matching funds.

(b) In addition, a county may qualify for an additional state incentive payment under Section 15200.7.

(c) Where more than one county has participated in the enforcement or collection, the federal and state AFDC incentive payments authorized by this section shall be made to the collecting county except that the federal non-AFDC incentive, and any non-AFDC incentive paid under Section 15200.95, shall be paid to the appropriate jurisdiction as determined by the State Department of Social Services.

(d) Where more than one state has participated in the enforcement or collection, the incentive payment, if any, shall be made in accordance with Section 15200.2.

(e) This section shall become operative on July 1, 1998.

SEC. 36. Section 15200.2 of the Welfare and Institutions Code is amended to read:

15200.2. (a) There is hereby appropriated out of any money in the State Treasury not otherwise appropriated, from which the department shall make payments to California counties, on any interstate support collections collected or distributed, or both, federal incentive funds on the amount received which qualify therefor. In addition, the department shall pay to each county on any

support collections distributed, regardless of the date of collection, a state incentive of 7.5 percent. This amount shall be paid on collections used to reduce or repay aid which is paid pursuant to this chapter, on collections paid to an aided family in the form of income which is not included in determining eligibility for assistance pursuant to federal law (also referred to as ''disregards''), on collections paid to an aided family in the form of income which is included in determining eligibility (also referred to as ''pass-ons'' and ''excess''), and for aid which is entitled to federal matching funds. In addition, a county may qualify for an additional state incentive payment under Section 15200.7.

(b) The department shall, by regulation, pay the incentive payment to the county distributing the support payment from another state.

(c) Where a county makes a collection for another state, the department shall make the federal incentive payment to the county making the collection. No state incentive shall be paid on collections made by a county on behalf of another state.

(d) This section shall become operative on July 1, 1998.

SEC. 37. Section 15200.3 of the Welfare and Institutions Code is amended to read:

15200.3. (a) There is hereby appropriated out of any money in the General Fund not otherwise appropriated, amounts from which the department shall make federal incentive payments to each county on nonfederally funded foster care support payments collected or distributed.

(b) The department shall pay to counties, in addition to the federal incentive for nonfederally funded foster care, a state incentive on collections used to repay the state's share of aid. The increased state incentive shall be paid to the extent and as specified in subdivision (c).

(c) The state incentive provided in subdivision (b) for nonfederal foster care cases shall only apply to those statewide collections distributed in a fiscal year in excess of the 1982–83 budget projection. From the excess, 7.5 percent, or the increased incentive, of collections for

nonfederal foster care cases shall be set aside for payment of these incentives. At the end of the fiscal year payment to each county of the incentive money shall be in proportion to the percentage of the total nonfederal cases support collection for the state which each county has distributed. The percentage incentive specified in subdivision (a) shall not exceed the total incentive provided by the state for federal foster care cases at any time but shall automatically be adjusted for any reductions. Any remaining funds shall be credited to offset expenditures for AFDC-FC.

(d) The Legislature finds and declares that the state incentive provided pursuant to this section is sufficient to reimburse counties for court and all other costs incurred through enforcement of parental liability in nonfederally funded foster care cases.

(e) This section shall become operative on July 1, 1998.

SEC. 38. Section 15200.7 of the Welfare and Institutions Code is amended to read:

15200.7. (a) In addition to funds appropriated pursuant to Sections 15200.1 and 15200.2, there is hereby annually appropriated from the General Fund to the State Department of Social Services beginning in fiscal year 1997–98, and based on the increase in fiscal year 1996–97 Aid to Families with Dependent Children child support collections above Aid to Families with Dependent Children child support collections in fiscal year 1995–96, a sum equal to 50 percent of the state's share of those increased collections. The sum shall be computed after payment of the incentive pursuant to increased collections. The sum shall be computed after payment of the incentive pursuant to Sections 15200.1 and 15200.2 has been taken out of the state share. The sum to be appropriated shall be computed in a similar manner annually thereafter.

(b) The sum appropriated pursuant to subdivision (a) shall be allocated by the department to each county which increased its collections and shall be based on each county's percentage of the total increased collections in those counties.

(c) This section shall become operative on July 1, 1998.

SEC. 39. Section 15200.8 of the Welfare and Institutions Code is amended to read:

15200.8. (a) The department shall establish a performance-based incentive system which will provide federal and state incentive funds to counties based on standards of performance in the child support program. The performance standards established shall determine the incentive rates to be paid on any support collections distributed on or after January 1, 1992.

(b) The performance-based incentive system shall have two levels of incentives.

(1) The first level, hereafter referred to as "Tier I," shall provide counties with a base incentive rate (referred to in this article as the base rate). Tier I also shall provide an increased incentive rate (referred to in this article as the compliance rate) to each county determined by the department to be in compliance with all federal and state child support enforcement program requirements. The compliance incentive rate may also be provided to each county that is in the process of conversion to the Statewide Automated Child Support System, as defined in subdivision (c) of Section 10815, if the department determines that there is a reasonable likelihood that the county would be in full compliance with all federal and state child support enforcement program requirements except for the fact that the county has been required to divert resources to prepare for conversion to the Statewide Automated Child Support System and if the department further determines that the county's efforts will bring the county into full compliance with all federal and state child support enforcement program requirements within a reasonable period of time.

(2) In determining Tier I county compliance, the department shall assess on at least an annual basis the accuracy and effectiveness of case processing based on the federal and state requirements in effect for the time period being reviewed, using a statistically valid sample of cases. The information for the assessment shall be based

on reviews conducted by either state or county staff, as determined by the department.

(A) Counties determined not to be in compliance shall be required to develop and submit a corrective action plan to the department.

(B) Counties under a corrective action plan shall be assessed on a quarterly basis until the department determines that they are in compliance with federal and state child support program requirements.

(3) In addition to determining Tier I compliance, the department shall collect information regarding whether cases on behalf of families receiving Aid to Families with Dependent Children are disproportionately represented in the portion of each county's case sample which is not in compliance. In the event disproportionate representation is found in a county's pool of noncompliant cases, the department shall require corrective action from that county. However, this corrective action shall not affect the county's entitlement to Tier I incentives.

(4) The second level (referred to in this article as Tier II), shall provide an additional incentive rate (referred to in this article as the performance rate), to counties that meet the performance standard levels as established by the department. No county shall qualify for payment of Tier II incentives in any year, month, or quarter in which it was not also eligible for the Tier I compliance rate.

(c) (1) The incentive rates shall be paid as a percentage of total distributed collections.

(2) ''Distributed collections'' means collections used to reduce or repay aid which is paid pursuant to this chapter; collections paid to an aided family; collections paid to a nonaided family regardless of the date of collection; collections paid to other state child support agencies on behalf of children residing in other states; and any other payments collected which qualify for federal incentives.

(d) Effective January 1, 1992, incentive payments shall be paid to the appropriate county jurisdiction as determined by the department.

(e) Nothing in this section shall preclude the department from adopting regulations pursuant to Section 11479.5.

(f) This section shall become inoperative on June 30, 1998, and as of January 1, 1999, is repealed, unless a later enacted statute, which becomes effective on or before January 1, 1999, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 40. Section 15200.85 of the Welfare and Institutions Code is amended to read:

15200.85. (a) Effective January 1, 1992, there shall be appropriated from the State Treasury sufficient funds, including federal incentives, from which the department shall pay to each county a base rate of 10 percent on any support collections distributed, regardless of the date of collection. The base incentive rate shall decrease by 1 percent annually each July 1, until July 1, 1995, at which time it shall be 6 percent for that fiscal year and every fiscal year thereafter.

(b) Effective January 1, 1992, the department shall pay to each county that is determined by the department to meet all requirements of Tier I, as described in paragraph (1) of subdivision (b) of Section 15200.8, a compliance incentive rate of 1 percent on any support collections distributed. This compliance rate shall increase by 1 percent annually each July 1, until July 1, 1995, at which time it shall be 5 percent for that fiscal year and every fiscal year thereafter.

(c) Counties which complete their corrective action plans pursuant to subparagraph (B) of paragraph (1) of subdivision (b) of Section 15200.8, shall qualify for the compliance rate incentive at the start of the quarter following completion.

(d) This section shall become inoperative on June 30, 1998, and as of January 1, 1999, is repealed, unless a later enacted statute, which becomes effective on or before January 1, 1999, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 41. Section 15200.9 of the Welfare and Institutions Code is amended to read:

15200.9. (a) Effective July 1, 1993, there shall be appropriated from the State Treasury sufficient funds, including federal incentives, from which the department shall pay a performance rate to those counties which meet Tier II performance standards, pursuant to paragraph (2) of subdivision (b) of Section 15200.8. The performance rate shall be paid in addition to that provided for under Section 15200.85 and shall be paid on distributed collections, regardless of the date of collection.

(b) The performance rate shall be a graduated scale up to a maximum rate of 1 percent. The maximum performance rate shall increase by 1 percent annually until July 1, 1995, at which time it shall be 3 percent for that fiscal year and every fiscal year thereafter.

(c) This section shall become inoperative on June 30, 1998, and as of January 1, 1999, is repealed, unless a later enacted statute, which becomes effective on or before January 1, 1999, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 42. Section 15200.91 is added to the Welfare and Institutions Code, to read:

15200.91. The Legislative Analyst's office shall conduct a study of the effectiveness, efficiency, and integrity of the child support performance review and corrective action processes described in Sections 15200.8 to 15200.9, inclusive, the department's regulations, and the operation of these processes at the state and county level and shall report its findings and recommendations for improvement, as appropriate, to the Legislature by March 1, 1997. The study shall be designed by the Legislative Analyst's office in consultation with the department, the State Library Research Bureau, a child support advocate group, and the California Family Support Council.

SEC. 43. Section 15200.95 of the Welfare and Institutions Code, as amended by Section 10 of Chapter 481 of the Statutes of 1995, is amended to read:

15200.95. (a) Each county shall be responsible for its nonfederal share of administrative expenditures for administering the child support program.

(b) Notwithstanding subdivision (a), effective July 1, 1991, to June 30, 1992, inclusive, counties shall pay the nonfederal share of the administrative costs of conducting the reviews required under Section 15200.8 from the savings counties will obtain as a result of the reduction in the maximum aid payments specified in Section 11450. Effective July 1, 1992, to June 30, 1993, inclusive, the state shall pay the nonfederal share of administrative costs of conducting the reviews required under Section 15200.8. Funding for county costs after June 30, 1993, shall be subject to the availability of funds in the annual Budget Act.

(c) In the event that the federal government does not provide the funding for federal financial participation in administrative costs of the child support program at the scheduled rates of 66 percent for regular federal financial participation and 90 percent for enhanced federal financial participation, the department shall increase the Tier I base incentive rate authorized under Section 15200.85 to supplant the dollar reduction to federal financial participation.

(1) This increase shall be based on the difference between the estimated dollar reimbursement resulting from the scheduled federal financial participation and the estimated dollar reimbursement resulting from the reduced federal financial participation rates. This increase to the base incentive rate, when applied to estimated total collections for the state fiscal year, shall approximately equal the federal reduction.

(2) This increase shall be determined annually, and shall apply to total distributed collections as defined in subdivision (c) of Section 15200.8.

(3) In no event shall the increased incentive rate exceed 4 percent in any fiscal year.

(4) This increase to the base incentive rate shall apply to the period of time in which the federal financial

participation rate in administrative expenditures is reduced.

(d) This section shall become inoperative on June 30, 1998, and as of January 1, 1999, is repealed, unless a later enacted statute, which becomes effective on or before January 1, 1999, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 44. Section 15200.95 of the Welfare and Institutions Code, as added by Section 11 of Chapter 481 of the Statutes of 1995, is amended to read:

15200.95. (a) Each county shall be responsible for its nonfederal share of administrative expenditures for administering the child support program.

(b) In the event that the federal government does not provide the funding for federal financial participation in scheduled rates of 66 percent for regular federal financial participation and 90 percent for enhanced federal financial participation, the department shall increase the incentive rates authorized under Sections 15200.1, 15200.2, and 15200.3 to supplant the dollar reduction to federal financial participation.

(1) This increase shall be based on the difference between the estimated dollar reimbursement resulting from the scheduled federal financial participation and the estimated dollar reimbursement resulting from the reduced federal financial participation rates. This increase to the base incentive rate, when applied to estimated total collections for the state fiscal year, shall approximately equal the federal reduction.

(2) This increase shall be determined annually, and shall apply to total distributed collections as defined in Section 15200.1.

(3) In no event shall this increase to the incentive rate exceed 4 percent in any fiscal year.

(4) This increase to the incentive rate shall apply to the period of time in which the federal financial participation rate in administrative expenditures is reduced.

(c) This section shall become operative on July 1, 1998.

SEC. 45. Section 16.5 of this bill incorporates amendments to Section 1357 of the Health and Safety Code proposed by this bill, AB 8, and SB 371. It shall only become operative if (1) this bill and either AB 8 or SB 371 or this bill and both AB 8 and SB 371 are enacted and become effective on or before January 1, 1997, (2) this bill and either AB 8 or SB 371 or this bill and both AB 8 and SB 371 amend Section 1357 of the Health and Safety Code, and (3) this bill is enacted last, in which case Section 16 of this bill shall not become operative.

SEC. 46. Section 27 of this act shall not become operative if Senate Bill 1866 is enacted and takes effect on or before January 1, 1997.

SEC. 47. Notwithstanding Section 17610 of the Government Code, if the Commission on State Mandates determines that this act contains costs mandated by the state, reimbursement to local agencies and school districts for those costs shall be made pursuant to Part 7 (commencing with Section 17500) of Division 4 of Title 2 of the Government Code. If the statewide cost of the claim for reimbursement does not exceed one million dollars ($1,000,000), reimbursement shall be made from the State Mandates Claims Fund.

Notwithstanding Section 17580 of the Government Code, unless otherwise specified, the provisions of this act shall become operative on the same date that the act takes effect pursuant to the California Constitution.

Approved _____, 1996

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Governor